MEDICAL ASSISTANCE
STATE North Carolina

THERAPEUTIC LEAVE

I. Therapeutic Leave for Nursing Facilities and Intermediate Care for the Mentally Retarded (ICF-MR):

(a) Each Medicaid eligible patient who is occupying a Nursing Facility (NF) bed or an Intermediate Care for the Mentally Retarded (ICF-MR) bed for which the North Carolina Medicaid Program is then paying reimbursement shall be entitled to take up to 60 days of therapeutic leave in any calendar year from any such bed without the facility in which the bed is located suffering any loss of reimbursement during the period of leave.

(b) The taking of such leave must be for therapeutic purposes only, and must be ordered by the patient's attending physician. The necessity for such leave shall be documented in the patient's plan of care and therapeutic justification for each instance of such leave entered into the patient's medical record.

(c) Facilities must reserve a therapeutically absent patient's bed for him, and are prohibited from deriving any Medicaid revenue for that patient other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken which exceed the legal limit.

(d) No more than 15 consecutive therapeutic leave days may be taken without approval of the Division of Medical Assistance.

(e) The therapeutic justification for such absence shall be subject to review by the State or its agent during scheduled on-site medical reviews.

(f) Facilities must keep a cumulative record of therapeutic leave days taken by each patient for reference and audit purposes. In addition, patients on therapeutic leave must be noted as such on the facility's midnight census. Facilities shall bill Medicaid for approved therapeutic leave days as regular residence days.

(g) The official record of therapeutic leave days taken for each patient shall be maintained by the State or its agent.

(h) Entitlement to therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving either inpatient or nursing services provided either elsewhere or at a different level of care in the facility of current residence when such services are or will be paid for by Medicaid.

(i) Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed by Medicaid.

(j) Effective July 1, 2005, entitlement to Therapeutic Leave is not applicable in the case of Medicaid Adult Care Home Personal Care Services (ACH-PCS).

MEDICAL ASSISTANCE
STATE North Carolina

II. Therapeutic Leave for Psychiatric Residential Treatment Facilities (PRTF) and Levels II-IV Residential Facilities:

(a) Each Medicaid eligible consumer who is occupying a Level II, Level III, or Level IV Residential Facility bed for which the North Carolina Medicaid Program is then paying reimbursement shall be entitled to take up to 45 days of therapeutic leave in any calendar year from any such bed without the facility in which the bed is located suffering any loss of reimbursement during the period of leave. Therapeutic leave is also limited to no more than 15 days within one calendar quarter (three months).

(b) The taking of such leave must be for therapeutic purposes only, and must be agreed upon by the consumer's treatment team. The necessity for such leave and the expectations involved in such leave shall be documented in the consumer's treatment/habilitation plan and the therapeutic justification for each instance of such leave entered into the consumer's record maintained at the Residential Facility's site.

(c) Therapeutic leave shall be defined as the absence of a consumer from the residential facility overnight, with the expectation of return, to participate in a medically acceptable therapeutic or rehabilitative facility as agreed upon by the treatment team and documented on the treatment/habilitation plan.

(d) Facilities must reserve a therapeutically absent consumer's bed for him, and are prohibited from deriving any Medicaid revenue for that consumer other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken which exceed the legal limit.

(e) No more than 5 consecutive days may be taken without the approval of the consumer's treatment team.

(f) Facilities must keep a cumulative record of therapeutic leave days taken by each consumer for reference and audit purposes. In addition, consumers on therapeutic leave must be noted as such on the facility's midnight census. Facilities shall bill Medicaid for approved therapeutic leave days as regular residence days.

(g) The official record of therapeutic leave days taken for each patient shall be maintained by the State or its agent.

(h) Therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving inpatient services or any other Medicaid-covered service in the facility of current residence or in another facility. Therapeutic leave cannot be paid when Medicaid is paying for any other 24 hour service.

(i) Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed by Medicaid.

.0101 REIMBURSEMENT PRINCIPLES

All certified nursing facilities participating in the North Carolina Medicaid Program are reimbursed on a prospective basis as set forth hereunder, except that state-operated facilities will be reimbursed their reasonable and allowable costs in accordance with the Medicare principles of reimbursement and with the provisions of Section .0103 and .0104 of this plan. This plan is developed in accordance with the requirements of 42 CFR 447 Subpart C – Payment for Inpatient Hospital and Long-Term Care Facility Services. Providers must comply with all federal regulations and with the provisions of this plan.

.0102 RATE SETTING METHODS

(a) A rate for skilled nursing care and a rate for intermediate nursing care is determined annually for each facility to be effective for dates of service for a twelve month period beginning each October 1. Each patient will be classified in one of the two categories depending on the services needed. Rates are derived from either filed, desk or field audited cost reports for a base year period to be selected by the state. Rates developed from filed cost reports may be retroactively adjusted if there is found to exist more than a two percent (2%) difference between the filed direct per diem cost and either the desk audited or field audited direct per diem cost for the same reporting period. Cost reports are filed and audited under provisions set forth in Rule.0104 of this Section. The criteria for determining the classification of each patient are presented in Appendix 1 of Attachment 3.1-A of the state Medicaid plan. The minimum requirements of the 1987 OBRA are met by these provisions.

(b) Each prospective rate consists of two components – a direct patient care rate and an indirect rate – computed and applied as follows:

(1) The direct rate is based on the Medicaid cost per day incurred in the following cost centers:

(A) Nursing,
(B) Dietary or Food Service,
(C) Laundry and Linen,
(D) Housekeeping
(E) Patient Activities,
(F) Social Services,
(G) Ancillary Services (includes several cost centers).

.0102 RATE SETTING METHODS

(a) A rate for nursing facility care is determined quarterly for each facility to be effective for dates of service for a three-month period beginning the first day of each calendar quarter. Rates are derived from either desk or field audited cost reports for a base year period to be selected by the state. For rates effective October 1, 2003, the FY01 cost reports shall be used as the base year period. Cost reports are filed and audited under provisions set forth in Section .0104.

(b) Each prospective rate consists of two components – a direct care rate and an indirect rate – computed and applied as follows:

(1) The direct care rate is that portion of the Medicaid daily rate that is attributable to:

(A) Case-mix adjusted costs defined as

(i) registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;

(ii) a direct allocation or proportionate allocation of allowable payroll taxes and employee benefits; and

(iii) the direct allowable cost of contracted services for RN, LPN and nurse aide staff from outside staffing companies.

(B) Non-case-mix adjusted costs defined as

(i) Nursing supplies;

(ii) Dietary or Food Service;

(iii) Patient Activities;

(iv) Social Services

(v) A direct allocation or proportionate allocation of allowable payroll taxes and employee benefits; and

(vi) Medicaid cost of Direct Ancillary services.

(2) Each facility's direct care rate shall be determined as follows:

(A) The per diem case-mix adjusted cost is determined by dividing the facility's case-mix adjusted base year cost by the facility's total base year inpatient days. This case-mix adjusted base year cost per diem shall be trended forward using the index factor set forth in Section .0102(e). A per diem neutralized case-mix adjusted cost is then calculated by dividing each facility's case-mix adjusted per diem cost by the facility cost report period case-mix index. The facility cost report period case-mix index is the resident-weighted average of quarterly facility-wide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the facility's base year cost reporting period. Example: An October 1, 2000 – September 2001 cost report period would use the facility-wide average case-mix indices for quarters ending December 31, 2000, March 31, 2001, June 30, 2001, and September 30, 2001.

(B) The per diem non-case-mix adjusted cost is determined by dividing the facility's non-case-mix adjusted base year cost, excluding the Medicaid cost of direct ancillary services, by the facility's total base year inpatient days plus the facility's Medicaid cost of direct ancillary services base year cost divided by the facility's total base year Medicaid resident days. This non-case-mix adjusted base year cost per diem shall be trended forward using the index factor set forth in Section .0102(e).

(C) The base year per diem neutralized case-mix adjusted cost and the base year per diem non-case-mix adjusted cost are summed for each nursing facility. Each facility's base year per diem result is arrayed from low to high and the Medicaid-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

(D) The statewide direct care ceiling is established at 110 percent of the base year neutralized case-mix adjusted and non-case mix adjusted Medicaid-day-weighted median cost.

(E) For each nursing facility, the statewide direct care ceiling shall be apportioned between the per diem case-mix adjusted component and the per diem non-case-mix adjusted component using the facility-specific percentages determined in .0102(b)(2)(C).

(F) On a quarterly basis, each facility's direct care rate shall be adjusted to account for changes in its Medicaid average case-mix index. The facility's direct care rate is determined as the lesser of (i) or (ii) as calculated below plus an incentive allowance.

(i) The facility's specific case-mix adjusted component of the statewide ceiling times the facility's Medicaid average case-mix index, plus each facility's specific non-case mix adjusted component of the statewide ceiling.

(ii) The facility's per diem neutralized case-mix adjusted cost times the Medicaid average case-mix index, plus the facility's per diem non-case-mix adjusted cost.

Effective January 17, 2005, the incentive allowance is equal to 60% times the difference (if greater than zero) of (i) minus (ii) as calculated above. The Division of Medical Assistance may negotiate direct rates that exceed the facility's specific direct care ceiling for ventilator dependent and head injury patients. Payment of such special direct care rates shall be made only after specific prior approval of the Division of Medical Assistance.

(G) For rates effective October 1, 2003, the Medicaid average case-mix index calculated as of March 31, 2003 shall be used to adjust the case-mix adjusted component of the statewide direct care ceiling. For rates effective January 1, 2004 and thereafter, the prior quarters Medicaid average case-mix index will be used to adjust the case-mix adjusted component of the statewide direct care ceiling. Example: January 1, 2004 rate will use the Medicaid average case-mix index calculated as of September 30, 2003.

(H) The statewide direct care ceiling will be adjusted annually using the index factor set forth in Section .0102(e). The facility's base year per diem neutralized case-mix adjusted cost plus the facility's base year per diem non-case-mix adjusted cost will be adjusted annually using the index factor set forth in Section .0102(e).

(3) The indirect rate is intended to cover the following costs of an efficiently and economically operated facility:

(A) Administrative and General,
(B) Laundry and Linen,
(C) Housekeeping,
(D) Operation of Plant and Maintenance/Non-Capital,
(E) Capital/Lease,
(F) Medicaid cost of Indirect Ancillary Services.

(4) Effective for dates of service beginning October 1, 2003, the indirect rate will be standard for all nursing facilities. Each facility's per diem indirect cost is the sum of 1) the facility's indirect base year cost, excluding the Medicaid cost of indirect ancillary services, divided by the facility's total base year inpatient days plus 2) the facility's Medicaid cost of indirect ancillary services base year cost divided by the facility's total base year Medicaid resident days. The base year per diem indirect cost, excluding property ownership and use and mortgage interest shall be trended forward using the index factor set forth in Section .0102(e) of this section. Each facility's base year per diem indirect cost is arrayed from low to high and the Medicaid-day-weighted median cost is determined. The indirect rate is established at 100 percent of the Medicaid-day-weighted median cost. The indirect rate shall be adjusted annually by the index factor set forth in Section .0102(e).

(c) Nursing facility assessments. An adjustment to the nursing facility payment rate calculated in accordance with Section .0102(b) is established, effective October 1, 2003, to reimburse Medicaid participating nursing facilities for the provider's assessment costs that are incurred for the care of North Carolina Medicaid residents. No adjustment will be made for the provider's assessment costs that are incurred for the care of privately paying residents or others who are not Medicaid eligible.

(d) Return on Equity. Effective fiscal year October 1, 2003 through September 30, 2004 and each year thereafter, the nursing facility payment rate calculated in accordance with Section .0102(b) shall be adjusted to include a return on equity capital add-on for those proprietary providers who received a FY01 return on equity capital payment. The return on equity capital add-on is equal to the facility's total FY01 return on equity capital payment divided by the facility's base year total Medicaid resident days.

(e) Index factor. The index factor shall be based on the Skilled Nursing Facility Market Basket without Capital Index published by Global Insight using the most current quarterly publication available annually as of August 1. The index factor shall not exceed that approved by the North Carolina General Assembly. If necessary, the Division of Medical Assistance shall adjust the annual index factor or rates in order to prevent payment rates from exceeding upper payment limits established by Federal Regulations.

(f) New Facilities and Transfer of Ownership of Existing Facilities

(1) New facilities are those entities whose beds have not previously been certified to participate or otherwise participated in the Medicaid program immediately prior to the operation of the new owner . A new facility's rate will be determined as follows and will continue to be reimbursed under this section until the incentive allowance percentage referenced in Section .0102(b)(2)(F) is equal to 100%:

(A) The direct care rate for new facilities will be equal to the statewide Medicaid day-weighted average direct care rate that is calculated effective on the 1st day of each calendar quarter. After the second full calendar quarter of operation, the statewide Medicaid day-weighted average direct care rate in effect for the facility shall be adjusted to reflect the facility's Medicaid acuity and the facility's direct care rate is calculated as the sum of the following:

(i) 65 percent of the statewide Medicaid day-weighted average direct care rate multiplied by the ratio of the facility's Medicaid average case-mix index (numerator) to the statewide Medicaid day-weighted average Medicaid case-mix index (denominator).

(ii) The statewide Medicaid day-weighted average direct care rate times 35%.

(B) The indirect rate for a new facility will be equal to the standard indirect rate in effect at the time the facility is enrolled in the Medicaid Program. The indirect rate shall be adjusted annually by the index factor set forth in Section .0102(e).

(C) A new facility's rate will include also the nursing assessment adjustment calculated in accordance with Section .0102(c).

(2) Transfer of ownership of existing facilities. Transfer of ownership means, for reimbursement purposes, a change in the majority ownership that does not involve related parties or related entities including, but not limited to, corporations, partnerships and limited liability companies. Majority ownership is defined as an individual or entity that owns more than 50 percent of the entity, which is the subject of the transaction. The following applies to the transfer of ownership of a nursing facility:

(A) For any facility that transfers ownership, the new owner shall receive a per diem rate equal to the previous owner's per diem rate less any return on equity adjustment received by the previous owner, rate adjusted quarterly to account for changes in its Medicaid average case-mix index. The old provider's base year cost report shall become the new facility's base year cost report until the new owner has a cost report included in a base year rate setting.

(B) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control of ownership for any facility certified for participation in Medicaid, the Division shall recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid program, regardless of when the services were rendered.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

(g) Each out-of-state provider is reimbursed at the lower of the appropriate North Carolina statewide Medicaid day-weighted average direct care rate plus the indirect rate or the provider's payment rate as established by the state in which the provider is located. For patients with special needs who must be placed in specialized out-of-state facilities, a payment rate that exceeds the North Carolina statewide Medicaid day-weighted average direct care rate plus the indirect rate may be negotiated. A facilities' negotiated rate for specialized services is based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review.

(h) Specialized Service Rates:

(1) Head Injury Intensive Rehabilitation Services –

(A) A single all-inclusive prospective rate combining both the direct and indirect cost components can be negotiated for nursing facilities that specialize in providing intensive rehabilitation services for head injured patients as specified by criteria in Appendix 3 to Attachment 3.1-A of the State Plan. The rate may exceed the maximum rate applicable to other Nursing Facility services. A facility must specialize to the extent of staffing at least fifty percent (50%) of its nursing facility licensed beds for intensive head injury rehabilitation services. The facility must also be accredited by the Commission for the Accreditation of Rehabilitation Facilities (CARF).

(B) A facility's initial rate is negotiated based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review upon the completion of an audited full year cost report. The negotiated rate shall not be less than the North Carolina statewide Medicaid day-weighted average direct care plus the indirect rate. A complete description of the facility's medical program must also be provided. Rates in subsequent years are determined by applying the index factor as set forth in Section .0102(e) to the rate in the previous year, unless either the provider or the State requests a renegotiation of the rate within sixty days (60) of the rate notice. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-D, Supplement 1, Page 1 of the State Plan.

(C) Cost reports for this service shall be filed in accordance with Section .0104 but there shall not be cost settlements for any difference between cost and payments. The negotiated rate is considered to provide payment for all financial considerations and shall not include the return on equity adjustment as defined in Section .0102 but shall include the nursing assessment adjustment as defined in Section .0102. The negotiated rate will be paid to the facility for services provided to head injured patients only. The per diem payment rate for non-head injured patients shall be the rate calculated in accordance with Section .0102 (b)–(e).

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

(1) Ventilator Services:

(A) Ventilator services approved for nursing facilities providing intensive services or ventilator dependent patients are reimbursed at higher direct rates as described in Section .0102(b)(2).

(B) A facility's initial direct rate shall be negotiated based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review upon the completion of an audited full year cost report. The negotiated rate shall not be less than the North Carolina statewide Medicaid day-weighted average direct care plus the indirect rate. Rates in subsequent years are determined by applying the index factor as set forth in Section .0102(e) to the negotiated rate in the previous year, unless either the provider or the State requests a renegotiation of the rate within sixty days (60) of the rate notice.

(C) Cost reports for this service shall be filed in accordance with Section .0104 but there shall not be cost settlements for any difference between cost and payments.

(D) A single all-inclusive prospective per diem rate combining both the direct and indirect cost components can be negotiated for nursing facilities that specialize in providing intensive services for ventilator-dependent patients. The negotiated rate is considered to provide payment for all financial considerations and shall not include the return on equity adjustment as defined in Section .0102. The negotiated rate will be paid to the facility for services provided to ventilator patients only. The per diem payment rate for non-ventilator patients shall be the rate calculated in accordance with Section .0102 (b) – (e). Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-D, Supplement 1, Page 1 of the State Plan.

(i) Religious Dietary Considerations.

(1) A standard amount may be added to a nursing facility's rate for special dietary need for religious reasons.

(2) Facilities must apply to receive this special payment consideration. In applying, facilities must document the reasons for special dietary consideration for religious reasons and must submit documentation for the increased dietary costs for religious reasons. Facilities must apply for this special benefit each time rates are determined from a new database. Fifty or more percent of the patients in total licensed beds must require religious dietary consideration in order for the facility to qualify for this special dietary rate add-on.

(3) The special dietary add-on rate may not exceed more than 140% of the base year neutralized case-mix adjusted Medicaid-day-weighted median cost determined under Section .0102(b)(2) and adjusted for inflation each year until a new database is used to determine rates.

.0103 REASONABLE AND NON-ALLOWABLE COSTS

(a) Providers have a responsibility to operate economically and efficiently so that their costs are reasonable. Providers are required to provide services at the lowest possible costs in compliance with Federal and State laws, regulations for licensing and certification, and standards for quality of care and patients' safety. Providers are also responsible for the financial actions of their agents (e.g., management companies) in this regard.

(b) The state may publish guidelines to define reasonable costs in certain areas after study of industry-wide cost conditions.

(c) The following costs are considered non-allowable facility costs because they are not related to patient care or are specifically disallowed under the North Carolina State Plan:

(1) bad debts;
(2) advertising – except personnel want ads, and one line yellow page (indicating facility address);
(3) life insurance (except for employee group plans);
(4) interest paid to a related party;
(5) contributions, including political or church-related, charity and courtesy allowances;
(6) prescription drugs and insulin (available to recipients under State Medicaid Drug Program);
(7) vending machine expenses;
(8) personal grooming other than haircuts, shampooing (basic hair care services) and nail trimming performed by either facility staff or barbers/beauticians. The facility may elect the means of service delivery. The costs of services beyond those provided by the nursing facility are the responsibility of the patient;
(9) state or federal corporate income taxes, plus any penalties and interest;

(10) telephone, television, or radio for personal use of patient;
(11) penalties or interest on income taxes;
(12) dental expenses – except for consultant fees as required by law;
(13) farm equipment and other expenses;
(14) retainers, unless itemized services of equal value have been rendered;
(15) physicians' fees for other than medical directors or medical consultants as required by law;
(16) country club dues;
(17) sitter services or private duty nurses;
(18) fines or penalties;
(19) guest meals;
(20) morgue boxes;
(21) leave days – except therapeutic leave;
(22) personal clothing; and
(23) ancillary costs that are billable to Medicare or other third party payors.

(d) For those non-allowable expenses which generate income, such as prescription drugs, vending machines, hair care (other than basic care), etc., expense should be identified as a non-reimbursable cost center where determinable. If the provider cannot determine the actual amount of expense which is to be identified, then the income which was generated must be offset in full to the appropriate cost center if the income reasonably covers the cost incurred. If income generated does not reasonably cover the cost incurred, an adjustment must be made to recognize a reasonable amount of non-reimbursable cost.

(e) For combination facilities (e.g. Nursing/Adult Care Home), providers must ensure that salary and wage expense coded or allocated to each area considers minimum staffing requirements (nursing hours per patient day or census statistics as appropriate).

.0104 COST REPORTING: AUDITING

(a) Each facility that receives payment from the North Carolina Medicaid Program must prepare and submit an annual report of its costs, including costs to meet the requirements of OBRA 87 (section 1919 of the Social Security Act) and other financial information to include, the facility's original working trial balance, year end adjusting journal entries, and the facility's daily midnight census records for the cost reporting period. The report must include costs from the fiscal period beginning on October 1 and ending on September 30 and must be submitted to the state on or before the December 31 that immediately follow the September 30 year end. A new provider must submit a report for the period beginning with the date of certification and ending on September 30. Hospital based nursing facilities and state operated facilities must file their cost reports within 150 days after their fiscal year ends. Facilities that fail to file their cost reports by the due date are subject to payment suspension as provided for under Section .0107(d)(4) until the reports are filed. The Division of Medical Assistance may extend the deadline 30 days for filing the report if, in its view, good cause exists for the delay. A good cause is an action that is uncontrollable by the provider.

(b) Cost report format. The cost report must be submitted on forms and in a format and medium approved by the Division of Medical Assistance. The account structure for the report is based on the chart of accounts published by the American Healthcare Association in 1979 but amended or modified to the extent necessary to meet the requirements of this plan. The Division of Medical Assistance will make one copy of the cost report format available to each facility (combination facilities receive only one) on or before September 1 of the reporting year for which the report is to be filed.

(c) Cost finding and allocation. Costs must be reported in the cost report in accordance with the following rules and in the order of priority stated.

(1) Costs must be reported in accordance with the specific provisions of this plan as set forth in this Section.

(2) Costs must be reported in conformance with the Medicare Provider Reimbursement Manual, HCFA 15.

(3) Costs must be reported in conformance with Generally Accepted Accounting Principles.

(d) The state will publish guidelines, consistent with the provisions of this plan, concerning the proper accounting treatment for items described in this Section. These guidelines may be modified prior to the beginning of each cost reporting period. In no case, however, shall any modifications be applied retroactively. A provider should request clarification in writing from the state if there is uncertainty about the proper cost center classification of any particular expense item.

(1) Nursing Cost Center includes the cost of nursing staff, medical supplies, and related operating expenses needed to provide nursing care to patients, including medical records (including forms), the Medical Director and the Pharmacy Consultant. The amount of nursing time provided to each patient must be recorded in order to allocate nursing cost between reimbursable and non-reimbursable cost centers.

(2) Dietary Cost center includes the cost of staff, raw food, and supplies needed to prepare and deliver food to patients.

(3) Laundry and Linen Cost Center includes the cost of staff, bed linens (replacement mattresses and related operating expenses needed to launder facility-provided items).

(4) Housekeeping Cost Center includes the cost of staff and supplies needed to keep the facility clean.

(5) Patient Activities Cost Center includes the cost of staff, supplies, and related operating expenses needed to provide supplies, and related operating expenses needed to provide appropriate diversionary activities for patients.

(6) Social Services includes the cost of social workers and related operating expenses needed to provide necessary social services to patients.

(7) Ancillary Cost Center includes the cost of all therapy services covered by the Medicaid program and billable medical supplies. Providers must bill Medicare Part B for those ancillary services covered under the Medicare Part B program. Ancillary cost centers include: Radiology, Laboratory, Physical Therapy, Occupational Therapy, Speech Therapy, Oxygen Therapy, Intravenous Fluids, Billable Medical Supplies, Parenteral/Enternal Therapy and life sustaining equipment, such as oxygen concentrators, respirators, and ventilators and other specifically approved equipment. Effective October 1, 1996, air fluidized beds (e.g. Clinitron beds), low air loss mattresses or beds and alternating pressure mattresses will be recorded in the life sustaining equipment cost center. This program is applicable to lease or depreciation expense incurred on or after October 1, 1996 regardless of when the equipment was initially leased or acquired.

(A) Effective October 1, 1994, a separate ancillary cost center shall be established to include costs associated with medically related transportation for facility residents. Medically related transportation costs include the costs of vehicles leased or owned by the facility, payroll costs associated with transporting residents and payments to third parties for providing these services.

(8) Administrative and General Cost Center includes all costs needed to administer the facility including the staff costs for the administrator, assistants, billing and secretarial personnel, personnel director and pastoral expenses. It includes the costs of copy machines, dues and subscriptions, transportation, income taxes, legal and accounting fees, start-up, and a variety of other administrative costs as set forth in the Chart of Accounts. Interest expense other than that stemming from mortgages or loans to acquire physical plant items shall be reported here.

(9) Capital/Lease:

(A) This cost center includes all allowable costs related to the acquisition and/or use of the physical assets including building, fixed equipment and movable equipment, that are required to deliver patient care, except for automobiles and the special equipment, as specified in .0104(d)(1) or .0104(d)(7) of this plan. Except for automobiles and the special equipment noted in section .0104(d)(1) and .0104(d)(7), it includes the following items:

(i) lease expense for all physical assets,

(ii) depreciation of assets, utilizing the straight line method, per AHA guidelines

(iii) interest expense of asset related liabilities, (e.g., mortgage expense),

(B) In establishing the allowable cost for depreciation and for interest on capital indebtedness, with respect to an asset which has undergone a change of ownership, the valuation of the asset shall be the lesser of allowable acquisition cost less accumulated depreciation to the first owner of record on or after July 18, 1984 who has received Medicaid payments for said asset or the acquisition cost to the new owner. Payment of rent by the Medicaid enrolled provider to the lessor of the facility shall constitute Medicaid payments under this plan. Depreciation recapture will not be performed at sale. The method for establishing the allowable related capital indebtedness shall be as follows:

(i) The allowable asset value shall be divided by the actual acquisition cost.

(ii) The product computed in step 1 shall be multiplied times the value of any related capital indebtedness.

(iii) The result shall be the liability amount upon which interest may be recorded at the rate set forth in the debt instrument or such lower rate as the state may prove is reasonable.

(10) Operation of Plant and Maintenance/Non-Capital Cost Center includes all cost necessary to operate or maintain the functionality and appearance of the plant. These include: buildings and equipment, automobile depreciation and lease expense, property taxes and property insurance.

(11) Equipment expense. Equipment is defined as an item with a useful life of more than two years and a value greater than five thousand dollars ($5000.00).

(12) Training Expense. Training expense must be identified in the appropriate benefiting cost center.

(13) The costs of training nurse aides in an approved competency and evaluation program must be identified separately on the cost report and may include the cost of purchasing programs and equipment that have been approved by the State for training or testing. These costs will be cost settled during the desk or field audit and are not included in the direct care and indirect cost centers.

(14) Home Office Costs. Home office costs are generally charged to the Administrative and General Cost Centers. In some cases, certain personnel costs which are direct patient care oriented may be allocated to "direct" patient care cost centers if time records are maintained to document the performance of direct patient care services. No home office overhead may be so allocated. The basis of this allocation among facilities participating in the North Carolina Medicaid program may be: (A) specific time records of work performed at each facility, or (B) patient days in each facility to which the costs apply relative to the total patient days in all the facilities to which the costs apply.

(15) Management Fees. Management fees are charged to the Administrative and General Cost Center. However, a portion of a management fee may be allocated to a direct patient care cost center if time records are maintained to document the performance of direct patient care services. The amount so allocated may be equal only to the salary and fringe benefits of persons who are performing direct patient care services while employed by the management company. Adequate records to support these costs must be made available to staff of the Division of Medical Assistance. The basis of this allocation among facilities participating in the North Carolina Medicaid program may be: (A) specific time records of work performed at each facility, or (B) patient days in each facility to which the costs apply relative to the total patient days in all the facilities to which the costs apply.

(16) Related Organization Costs. It is the nursing facility's responsibility to demonstrate by convincing evidence to the satisfaction of the Division of Medical Assistance that the costs are reasonable. Reasonable costs of related organizations are to be identified in accordance with direct and indirect cost center categories as follows:

(A) Direct Cost:

(i) Compensation of direct care staff such as nursing personnel (aides, orderlies, nurses), food service workers, and other personnel who are accounted for in the direct cost center.

(ii) Supplies and services that would normally be accounted for in a direct cost center.

(iii) Capital, rental, maintenance, supplies/repairs and utility costs (gas, water, fuel, electricity) for facilities that are not typically a part of a nursing facility. These facilities might include such items as warehouses, vehicles for delivery and offices which are totally dedicated or clearly exceed the number, size, or complexity required for a normal nursing facility, its home office, or management company.

(iv) Compensation of all administrative staff who perform no duties which are related to the nursing facility or its home office and who are neither officers nor owners of the nursing facilities or its home office.

(B) Indirect Cost:

(i) Compensation of indirect staff such as housekeeping, laundry and linen, maintenance, and other personnel who would normally be accounted for in the indirect cost center.

(ii) Capital, rental, maintenance supplies/repairs, and utility costs which are normally or frequently a part of a nursing facility. This would include, for example, kitchen and laundry facilities.

(iii) Home office costs except for salary and fringe benefits of Personnel, Accounting and Data Processing staff which are allocated by approved methods are direct costs when the work performed is specific to the related organization that provides a direct care service or product to the provider.

(iv) Compensation of all administrative staff who perform any duties for the nursing facility or its home office.

(v) All compensation of all officers and owners of the nursing facility or its home office, or parent corporation.

The related organization must file a Medicaid Cost Statement (DMA-4083) identifying their costs, adjustments to costs, allocation of costs, equity capital, adjustments to equity capital, and allocations of equity capital along with the nursing facilities cost report. A home office, or parent company, will be recognized as a related organization. Auditable records to support these costs must be made available to staff of the Division of Medical Assistance and its designated contract auditors. Undocumented costs will be disallowed.

It is the nursing facility's responsibility to demonstrate by convincing evidence to the satisfaction of the Division of Medical Assistance that the criteria in the Provider Reimbursement Manual, Section 1010, has been met in order to be recognized as an exception to the related organization principle.

When a related organization is deemed an exception; (1) reasonable charges by the related organization to the nursing facility are recognized as allowable costs; (2) receivables/payables from/to the nursing facility and related organization deemed an exception are not adjusted from the nursing facility's balance sheet in computing equity capital.

(e) Auditing. All filed cost reports shall be desk audited in accordance with the provision of this plan. An Audit Adjustment Report shall be issued within one year of the date the cost report was filed or within one year of December 31 of the fiscal year to which the report applies, whichever is later. The state may elect to perform field audits on any filed cost reports within three years of the date of filing and issue a final Audit Adjustment Report on a time schedule that conforms to Federal law and regulation. If the state does not field audit a facility a final Audit Adjustment Report shall be issued based on the desk audited findings. The state may reopen and field audit any cost report after the final Audit Adjustment Report to comply with Federal law and regulation or to enforce laws and regulations prohibiting abuse of the Medicaid Program and particularly the provisions of this reimbursement plan.

(f) Penalties. Providers who fail to fully and accurately complete cost reports or who fail to furnish required documentation and disclosures for cost reports required under this Plan may be subject to penalties for non-compliance. Issues which are subject to penalties include, but are not limited to, material miscoding of cost from Indirect to Direct cost centers or from Non-Reimbursable to Reimbursable cost centers, inaccurate identification of census data or ancillary charges by payor type, and failure to disclose related parties including those deemed non-related by exception. Errors in a filed cost report which result in an adjustment greater than one percent (1%) of a provider's reimbursable total cost per the filed cost report reported in the cost report shall be subject to penalty. Penalty will be defined as the dollar value equal to five percent of the Medicaid percentage, as defined by occupancy, of the adjustment.

.0105 CASE-MIX INDEX CALCULATION

(a) The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility to the Division of Facility Services. The following case-mix indices shall be the basis for calculating facility average case-mix indices to be used in determining the facility's direct care rate.

RUG Code	Case-Mix Index	RUG Code	Case-Mix Index	RUG Code	Case-Mix Index
SE3	2.08	CB2	1.13	PE2	0.97
SE2	1.70	CB1	1.01	PE1	0.96
SE1	1.45	CA2	1.02	PD2	0.91
RAD	1.68	CA1	0.92	PD1	0.83
RAC	1.41	IB2	0.89	PC2	.82
RAB	1.28	IB1	0.82	PC1	.80
RAA	1.06	IA2	0.74	PB2	.66
SSC	1.40	IA1	0.64	PB1	.61
SSB	1.29	BB2	0.86	PA2	.60
SSA	1.25	BB1	0.80	PA1	.57
CC2	1.39	BA2	0.72		
CC1	1.23	BA1	0.61		

(b) Each resident in the facility on the last day of each quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available with an assessment reference date on or prior to the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a". If the most current assessment available with an assessment reference date on or prior to the last day of the calendar quarter is a delinquent MDS then the RUG-III code assigned shall be a BC1-delinquent and the lowest case-mix index in paragraph "a" will be applied. A delinquent MDS is defined as 121 days from the R2b date of the MDS assessment (completion date). From the individual resident case-mix index, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

(c) The facility-wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid or Medicaid pending is known to be the per diem payor source on the last day of the calendar quarter.

.0106 RECONSIDERATION REVIEWS

(a) Providers may either accept agency reimbursement determinations or request a reconsideration review in accordance with the procedures set forth in 10A NCAC 22I and 22J.

(b) Indirect rates shall not be adjusted on reconsideration review.

(c) Direct rates may be adjusted for the following reasons:

(1) to accommodate any changes in the minimum standards or minimum levels of resources required in the provision of patient care that are mandated by state or federal laws or regulation;

(2) to correct any adjustments or revisions to ensure that the payment rate is calculated in accordance with Section .0102.

.0107 PAYMENT ASSURANCE

(a) The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan and the Participation agreement, the amount determined under the plan. In addition, Nursing Facilities must be enrolled in the Title XVIII Program. However, State-operated nursing facilities are not required to be enrolled in the Medicare program.

(b) The payment methods and standards set forth herein are designed to enlist the participation of any provider who operates a facility both economically and efficiently. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan. This reimbursement plan is effective upon approval of the State Plan for Medical Assistance.

(c) In all circumstances involving third party payment, Medicaid is the payor of last resort. No payment will be made for a Medicaid recipient who is also eligible for Medicare, Part A, for the first 20 days of care rendered to skilled nursing patients. Medicaid payments for coinsurance for such patients will be made for the subsequent 21st through the 100th day of care. The Division of Medical Assistance will pay an amount for each day of Medicare Part A inpatient coinsurance, the total of which will equal the facility's Medicaid per diem rate less any Medicare Part A payment, but no more than the Medicare coinsurance amount. In the case of ancillary services, providers are obligated to:

(1) maintain detailed records or charges for all patients;

(2) bill the appropriate Medicare Part B carrier for all services provided to Medicaid patients that may be covered under that program; and

(3) allocate and appropriate amount of ancillary costs, based on these charge records adjusted to reflect Medicare denials of coverage, to Medicare Part B in the annual cost report. For failure to comply with this requirement, the state may charge a penalty of up to 5 percent of a provider's indirect patient care rate for each day of care that is provided during the fiscal year in which the failure occurs. This penalty shall not be considered an allowable cost for cost reporting purposes.

(4) Properly bill Medicare or other third-party payors or have disallowance of any related cost claimed as Medicaid cost.

(d) The state may withhold payments to providers under the following circumstances:

(1) Upon determination of any sum due the Medicaid Program or upon instruction from a legally authorized agent of State or Federal Government, the state may withhold sums to meet the obligations identified.

(2) The state may arrange repayment schedules within the limits set forth in federal regulations in lieu of withholding funds.

(3) The state may charge reasonable interest on over-payments from the date that the overpayment occurred.

(4) The State may withhold up to twenty (20) percent per month of a provider's payment for failure to file a timely cost report and associated accounting records. The funds will be released to the provider after a cost report is acceptably filed. The provider will experience delayed payment while the check is routed to the State and split for the amount withheld.

.0108 REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITIES

(a) A certified State-operated nursing facility is reimbursed for the reasonable costs that are necessary to efficiently meet the needs of its patients and to comply with federal and state laws and regulations. The costs are determined in accordance with Sections .0103 and .0104 except that annual cost reports are required for the fiscal year beginning on July 1 and ending on the following June 30 and must be submitted to the Division of Medical Assistance within 150 days after their fiscal year end. Payments will be suspended if reports are not filed. The Division of Medical Assistance may extend the deadline for filing the report, if in its view, good cause exists for the delay. The Medicare principles for the reimbursement of skilled nursing facilities will be utilized for the cost principles that are not specifically addressed in the State Plan.

(b) A per diem rate based on the provider's estimated annual cost divided by patient days will be used to make interim payments. A desk audit will be performed on each annual cost report to determine the amount of Medicaid reasonable cost and the amount of interim payments received by the provider.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

Payment for Head Injury and Ventilator Nursing Beds:

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

NC General Assembly legislation mandates that effective July 1, 2005, reimbursement rates for these programs (Head Injury and Ventilator Nursing Beds) for the state fiscal years 2005-2006 and 2006-2007 will remain at the rate in effect as of June 30, 2005, except rates may be adjusted downward.

Reference: Attachment 4.19-D, Page 6 and 7